

June 2018

Healthcare Systems and Services Practice

# From revenue cycle management to revenue excellence

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# From revenue cycle management to revenue excellence

*Technology and payment trends are reshaping the revenue cycle. Providers that want to improve yield must think about revenue cycle management in a whole new way, which we call revenue excellence.*

Across the country, hospitals and health systems continue to struggle with downward pressure on reimbursement and yield. At the same time, most are experiencing significant increases in costs associated with the revenue cycle. In this environment, many organizations are looking to their revenue cycle management (RCM) teams to deliver significant performance improvement at reduced cost—with mixed results.

If providers are going to be able to both improve performance—both yield and cash collections—and obtain a step-change improvement in efficiency, they must think about RCM in a new way, which we call *Revenue Excellence*. In contrast to traditional RCM, revenue excellence begins with a belief that improved performance requires ownership throughout the organization, places the patient experience at the center of all collections activities, and leverages analytics and technology in new ways to prevent revenue cycle problems before they occur.

In this paper, we describe the major forces that have challenged RCM performance for the past five years. We then address the most important question: How can providers shift to revenue excellence?

## External trends challenging performance

Over the past five years, hospitals and health systems across the country have faced new challenges to RCM performance. The decrease in the number of uninsured individuals following passage of the Affordable Care Act (ACA) has been offset by increased complexity in other areas. Three underlying trends are the primary drivers of the increased complexity and accompanying performance challenges: shifts in payment responsibility and bad debt, changes in payment requirements, and heightened administrative burdens. These trends, combined with broader changes in how and where care is delivered, have created significant new obstacles for the revenue cycle.

### **Shifts in payment responsibility and bad debt**

By far, one of the most important trends in healthcare in recent years has been the shift in financial responsibility towards patients and managed care plans. Two specific factors account for this trend:

- Most patients now bear a greater share of the overall financial burden
- An increasing proportion of patients covered by government-sponsored insurance are now in managed care plans

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**Shift of the financial burden to patients.**

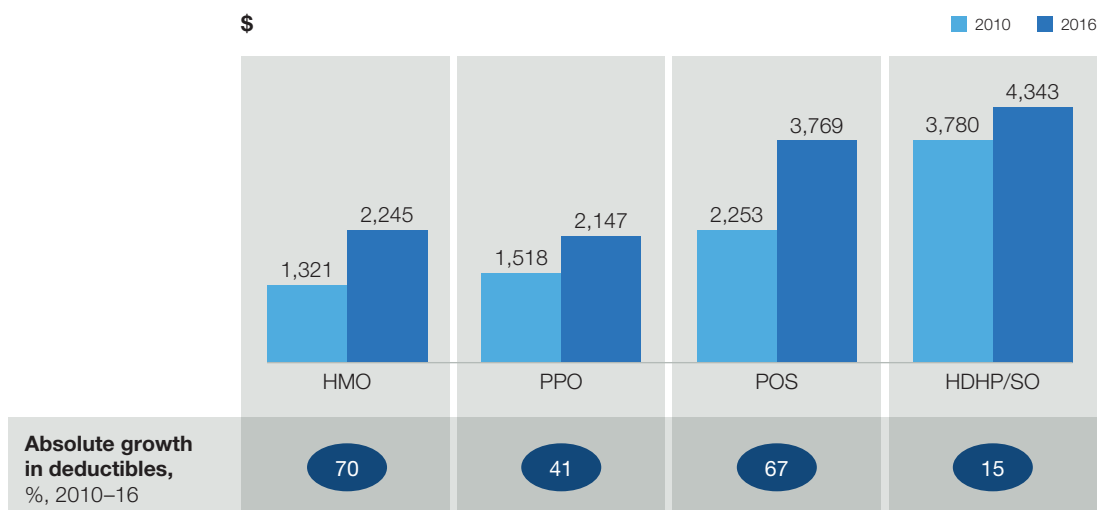
Under the ACA, the uninsured rate among adults fell from nearly 18% in 2013 to 12.2% in 2017.<sup>1</sup> Consequently, many providers saw their total outstanding liabilities from uninsured patients decrease. However, they also experienced a corresponding increase in unpaid liabilities from insured patients, making the net effect on their bottom lines nearly null. Changes in health insurers' plan designs were largely responsible for the latter shift. Between 2010 and 2016, for example, the deductibles for families of four with employer-sponsored health insurance rose 15% to 70%, depending on the plan type (Exhibit 1).<sup>2</sup> During that time, average American incomes largely remained flat, leaving patients with less disposable income to pay their growing healthcare bills.<sup>3</sup> As a

result, effectively estimating, communicating, and collecting balances from patients who are underinsured or likely to have large out-of-pocket liabilities has become a top priority for providers.

**Shift into managed government plans.**

There has also been a shift away from traditional government health insurance plans to managed portfolios. An increasing proportion of Medicaid beneficiaries (80% in 2017, compared with 64% in 2007) are enrolled in plans run by managed care organizations.<sup>4</sup> Similarly, the proportion of Medicare beneficiaries enrolled in Medicare Advantage plans was 33% in 2017, up from 19% a decade earlier.<sup>5</sup> This shift may have implications for providers, because early studies have found evidence that managed care plans use dif-

**EXHIBIT 1 Average annual deductibles for families with employer-sponsored health plans<sup>1</sup>**



HDHP/SO, high-deductible health plan with a savings option; HMO, health maintenance organization; POS, point-of-service plan; PPO, preferred provider organization.

<sup>1</sup>Average annual general health plan deductibles for all plans except HMOs are for in-network services.

Sources: Kaiser Family Foundation/Health Research and Education Trust. *Employer Health Benefits: 2016 Annual Survey*. September 16, 2016; US Census Bureau's American Community Survey income data tables 2010-16

<sup>1</sup>Auter Z. US uninsured rate steady at 12.2% in fourth quarter of 2017. Gallup.com. January 18, 2018.

<sup>2</sup>Kaiser Family Foundation/Health Research and Education Trust. *Employer Health Benefits: 2016 Annual Survey*. September 16, 2016.

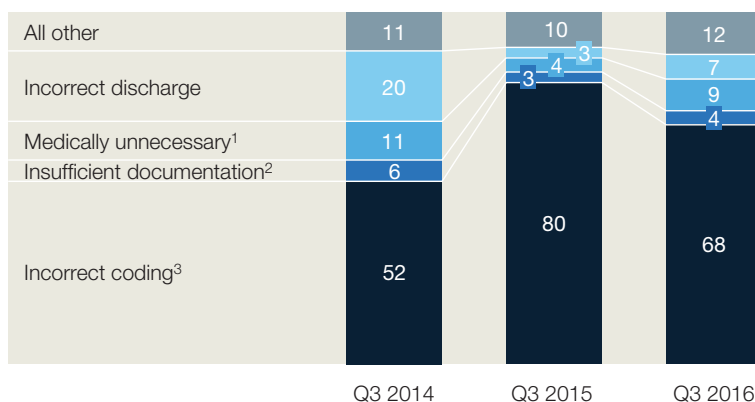
<sup>3</sup>US Census Bureau. American Community Survey income data tables. 2010-16.

<sup>4</sup>Centers for Medicare and Medicaid Services. State Medicaid and CHIP applications, eligibility determinations, and enrollment data reporting. 2007-17.

<sup>5</sup>Jacobson G et al. Medicare Advantage 2017 Spotlight: Enrollment Market Update. Kaiser Family Foundation. June 6, 2017.

## EXHIBIT 2 Top reasons for claims denials, as reported in the national RACTrac Survey

% of participating hospitals' denials, by dollar value



<sup>1</sup>Includes “short stay medically unnecessary,” “medically unnecessary inpatient stay longer than 3 days,” and “other medically unnecessary.”

<sup>2</sup>Same as “no or insufficient documentation in the medical record.”

<sup>3</sup>Includes “incorrect MS-DRG or other coding error” and “incorrect APC or other outpatient coding error.” (APC stands for ambulatory payment classifications.)

Sources: American Hospital Association. RACTrac Surveys, 2014–16; DiChiara J. Hospitals facing more payment claims audits, costly denials. *RevCycle Intelligence*. December 7, 2015

ferent approaches to claims review than traditional government plans do, and may have different timelines to payment.<sup>6</sup>

Because of these two trends, many providers have experienced changes in the size of the liabilities owed by both patients and payers, the time required for collections, and balance-after-insurance bad debt.

### Changes in payment requirements

Another important trend relates to the requirements providers must meet to collect revenues owed from payers. Specifically, three changes in payment methodologies—the adoption of ICD-10,<sup>7</sup> stricter enforcement of medical policies, and risk-adjusted revenue—have created challenges for providers.

The rollout of ICD-10, for example, expanded the number of possible code options by about eight times to 140,000 codes.<sup>8</sup> As such, coding teams must have access to much more nuanced and comprehensive documentation to accurately code claims. Furthermore, many insurers have increased their enforcement of contract terms and scrutiny of claims, putting greater focus on medical necessity as a prerequisite for payment. According to a recent report, 81% of recovery audit contractor denials in Q3 2016 were based on factors related to either documentation or medical necessity (Exhibit 2).<sup>9</sup> Even when these two changes have not raised write-off levels, they have increased costs at most providers (because additional resources are required to create detailed clinical documentation, train coding teams on more nuanced code selection,

<sup>6</sup>For more information on reported denial rates and time to payment, see the recent paper by Gottlieb JD et al. The complexity of billing and paying for physician care. *Health Affairs*. 2018;37(4):619-26.

<sup>7</sup>World Health Organization. *International Statistical Classification of Diseases and Related Health Problems*. Tenth revision. 1992.

<sup>8</sup>There were approximately 17,000 code options under ICD-9 and there are approximately 140,000 code options under ICD-10.

<sup>9</sup>American Hospital Association. 2016 RACTrac Survey.

and process and respond to claim follow-up activity). Furthermore, to obtain the appropriate risk-adjusted revenue from Medicare, providers must put additional focus on documenting the acuity of patient conditions.

The result: to maintain yield, providers must be smarter with their time and limited resources to ensure that documentation is accurate and denials are prevented whenever possible. Accomplishing this requires more effective engagement and collaboration with clinical staff and better use of electronic health systems to ensure proper support for billing teams.

### Heightened administrative burdens

The ACA reduced providers' administrative burden in certain areas, especially by streamlining enrollment processes and encouraging electronic transactions. Adoption rates for standardized electronic transactions have been high in some areas, and this trend has lowered the burden for providers and payers alike. Among the commercial plans offered in 2016, for example, the adoption rates for electronic eligibility/benefit verification and claims submission were 76% and 94%, respectively.<sup>10</sup>

However, several trends have increased the overall administrative burden in recent years (Exhibit 3). In particular, the amount of financial clearance activity (especially authorization requirements) has risen, and these transactions are still largely manual. Some of the growth in clearance activity has been driven by the rising prevalence of narrow networks, but some has resulted

from the increased attention now being paid to medical policies. Between 2013 and 2015, for example, authorization request volumes grew to 32 million, from 24 million, a 15% annual rise.<sup>11</sup> As a result, in 2016 physicians and staff spent an average of 16.4 hours per week on authorization activities and processed 37 authorizations each week; furthermore, because of the slow adoption of electronic authorization requests, nearly 60% of physicians and staff had to wait at least one business day to get a response to at least one of their authorization requests.<sup>12</sup> All of these changes have increased operating costs, particularly for patient-access functions (e.g., financial clearance teams). The continued use of manual processes is a leading contributor to the growth in rejections outlined above.

### A new framework: Integrated revenue excellence

Because the challenging external environment has made many RCM processes more complex and difficult, providers need to think differently if they are to significantly improve performance while reducing costs and complexity. We believe that achieving that level of performance will be table stakes for hospitals and health systems going forward.

Achieving revenue excellence requires a comprehensive approach. A range of stakeholders, including the managed care, revenue cycle, finance, and clinical care teams, must be brought together. Analytics and technology must be leveraged so the staff can work “smarter” rather than harder. A hard look must be taken at the costs associated with the

<sup>10</sup>CAQH Explorations. 2016 CAQH Index: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings. January 2017.

<sup>11</sup>CAQH Explorations. 2013 and 2015 CAQH Index Reports.

<sup>12</sup>American Medical Association. 2016 AMA prior authorization physician survey results. January 2017.

revenue cycle, and opportunities to reduce costs through automation and technology must be sought. Below, we outline the primary steps providers must take (Exhibit 4).

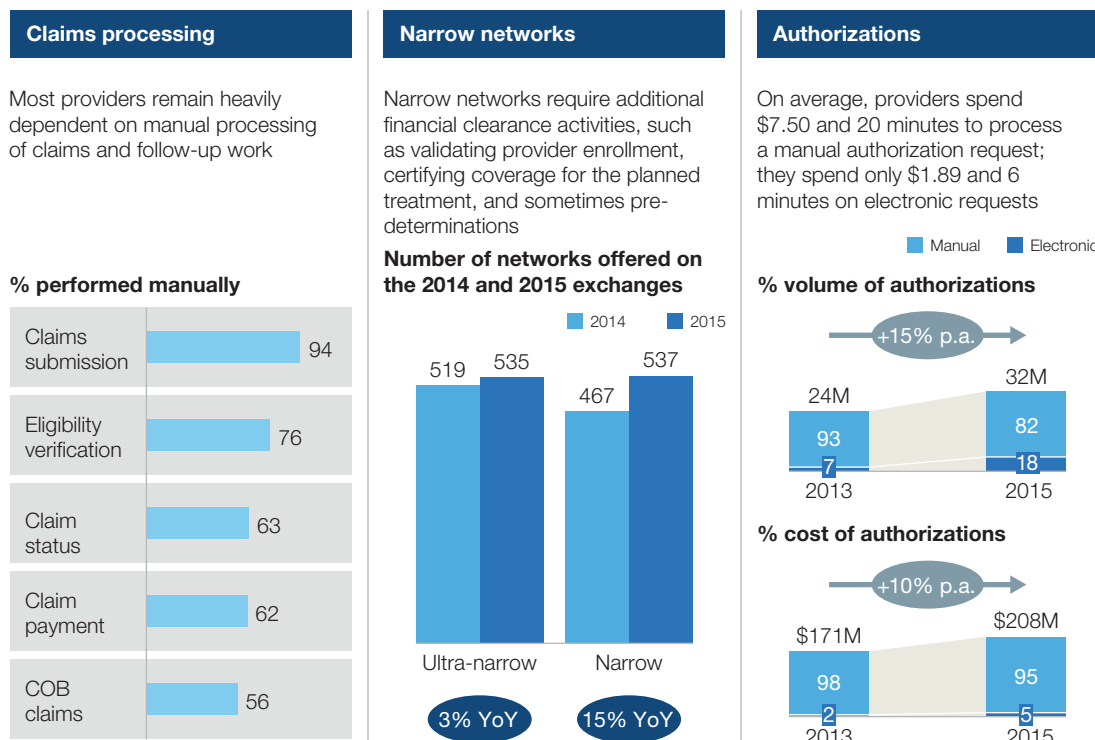
### Establishing cross-functional revenue ownership

Unlocking a new level of performance requires hospital and health system executives to create an operating model that fosters greater collaboration and partnership between traditionally siloed stakeholders: not only managed care, revenue cycle, finance, and clinical care, but also legal, case management, and more. To

understand why greater collaboration is necessary, consider how ownership of revenue-influencing activities is typically allocated at most providers today (Exhibit 5).

To reduce or eliminate organizational silos and increase collaboration between functions, provider executives will need to use a range of structural and “softer” levers. For example, they should create aligned incentives and performance metrics, simplify and consolidate the organization structure, share cross-functional key performance indicators among stakeholders, and establish scalable

EXHIBIT 3 Trends that have increased the administrative burden



COB, coordination of benefits; p.a., per anum; YoY, year on year.

Sources: CAQH Index Reports, 2013–16; MPACT model; Bauman N et al. Hospital networks: Evolution of the configurations on the 2015 exchanges. McKinsey white paper. April 2015

EXHIBIT 4 The primary steps toward revenue excellence

<p><b>Establishing cross-functional revenue ownership</b></p>	<ul style="list-style-type: none"> <li>• Partner with stakeholders outside of the revenue cycle to unlock new levels of performance</li> <li>• In particular, elevate the role of finance, managed care, and clinical leadership</li> </ul>
<p><b>Enhancing patient engagement</b></p>	<ul style="list-style-type: none"> <li>• Optimize the patient experience—and, as a result, the patient’s likelihood to return—by optimizing the patient engagement strategy</li> <li>• Increase transparency for patients regarding cost and liabilities before treatment is given</li> <li>• Simultaneously, manage the increasing balance-after-insurance liabilities many patients face and improve the collection process</li> </ul>
<p><b>Digitizing and optimizing operations</b></p>	<ul style="list-style-type: none"> <li>• Digitize and automate operations to increase both effectiveness and efficiency, offset the rising cost of the revenue cycle, reduce complexity, and improve yield</li> <li>• Leverage advanced analytics to enable better decision making and resource management</li> </ul>
<p><b>Optimizing revenue cycle management across functions</b></p>	<ul style="list-style-type: none"> <li>• Ensure that revenue operations are standardized across sites of care and information can flow seamlessly</li> <li>• Evolve revenue cycle management practice to account for shifts in sites of care, increased administrative burden, and growth of narrow networks</li> <li>• Ensure that the patient experience and pre-service activities are streamlined and standardized across sites of care</li> </ul>

feedback mechanisms to “upstream” teams. In our experience, some providers have made progress in these areas, but the results realized to date are often insufficient to achieve revenue excellence. Progress needs to continue.

**Enhancing patient engagement**

Providers today are seeking broader and deeper means to engage patients, a trend that is particularly essential in the revenue cycle for two reasons. First, patients are facing a growing financial burden while their ability to pay is decreasing. Second, revenue cycle team members often now have a high volume of very significant nonclinical interactions with patients to discuss highly sensitive topics, such as financial liability. As a result, these teams can play a very important role in improving patient satisfaction.

In recent years, providers have made significant investments to more actively engage patients, often through strategies focused on encouraging online interactions. (For example, many providers now allow patients to view and pay bills online.) We believe, however, that if providers are to reap the full benefits of patient engagement and improve their collection rates, additional effort is required—they must have open, honest conversations with patients about costs *before* care is delivered.

Although clinical topics have been—and will continue to be—a core element of communications between providers and patients, financial topics need to be given more attention and focus. McKinsey research has shown that satisfaction levels are strongly influenced by the information patients are given before, as well as after, a procedure.<sup>13</sup>

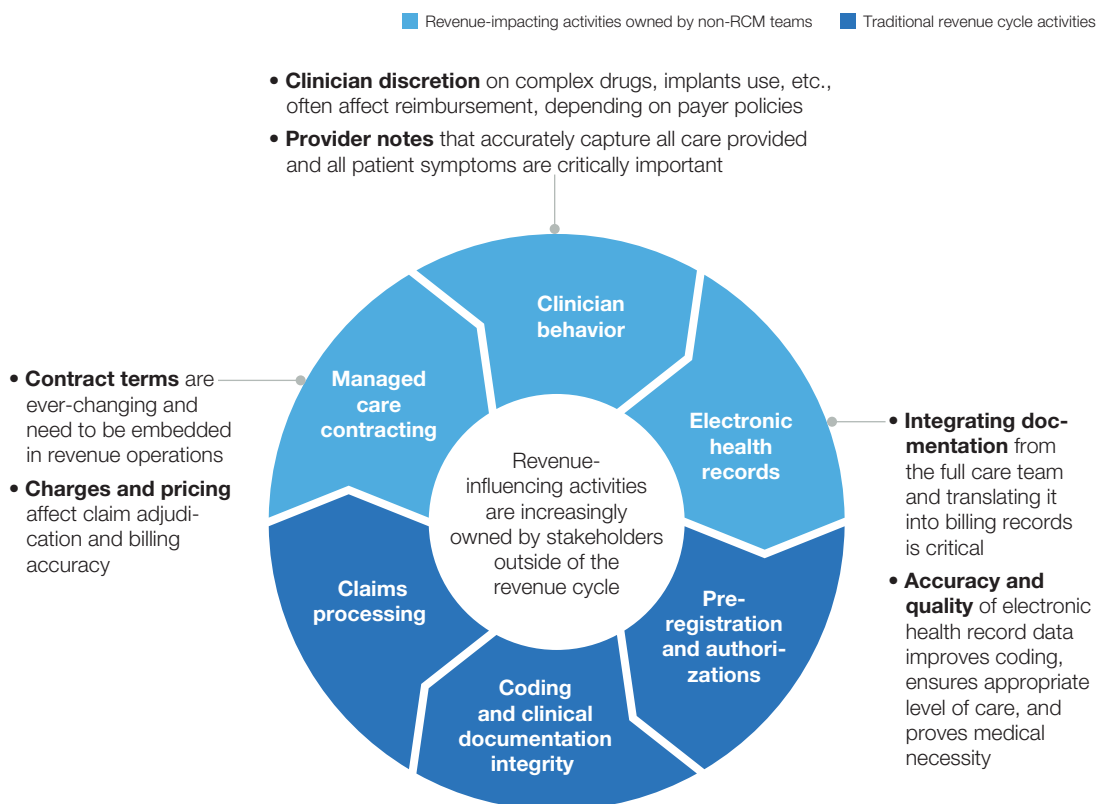
<sup>13</sup>Cordina J et al. Debunking common myths about healthcare consumerism. McKinsey white paper. December 2015.

Transparent discussions about financial issues could help patients understand what their out-of-pocket liabilities are likely to be and thus enable them to better prepare for the financial obligations they may face. Today, most interactions about financial topics occur after the time of service, when patients' options largely consist of payment or default.

Provider executives should therefore focus on increasing transparency in their organization's communications with patients and create a culture centered on customized, holistic engagement on both clinical and

financial topics between their teams and patients before the time of service. Increased transparency during a single encounter with a patient is not enough—providers should focus on their overall relationship with each patient. Admittedly, many barriers to improving patient engagement exist (e.g., high turnover among patient-facing staff and difficulties in segmentation when creating customized patient pathways). Nevertheless, today's providers can take advantage of a range of start-ups and technological innovations that would enable them to take a more

**EXHIBIT 5 Typical ownership of revenue-influencing activities at most providers today**



RCM, revenue cycle management.



thoughtful—and often digitally-based—approach to connecting with their patients.

### **Digitizing and optimizing operations**

Hospitals and health systems will continue to face pricing pressures as well as rising claims processing workloads. Given that funding to increase head count is limited, RCM teams will increasingly need to leverage technology to replace highly manual processes and take greater advantage of available data and advanced analytics.

[Digitizing and automating for both effectiveness and efficiency.](#) Leveraging digital tools and automating activities can improve the effectiveness as well as the efficiency of the teams. Across industries, we are seeing a shift toward automation and digitization of a range of activities. In finance, for example, it is estimated that activities that currently take up about 43% of employees' time (e.g., mortgage application processing, verifying financial data, analyzing market trends) could be automated.<sup>14</sup> Many administrative activities in healthcare could similarly be automated. To start, providers should focus on low-complexity, highly repetitive tasks—in these cases, automation can reduce the propensity for human error and free up additional team time for more complex activities. Some of the more interesting (and currently available) advances include software that can predict clinical codes based on clinical documentation, voice recognition software to reduce reliance on manual data entry, machine learning to automate bill scrubbing and modifier usage, and software that can automate straightforward appeals with remittance data.

[Relying on advanced analytics for business decisions.](#) Because capacity can increasingly be created by leveraging digital tools and automating activities, many providers are using advanced analytics to enable better decision making and resource management. For example, predictive analytics can now be used to better understand rejection and denial trends. Data and analytics can also be used to streamline billing-office processes and develop more targeted or “smarter” claims processing approaches.

### **Optimizing RCM across sites**

Access points and mechanisms of care delivery are evolving. For example, new approaches to chronic care management are being developed.<sup>15</sup> Patients are increasingly using ambulatory surgical centers, outpatient clinics, and other sites of care besides the hospital. Providers will need a more “seamless” revenue cycle if they are to respond effectively to these changes:

[Communicating more smoothly across sites of care.](#) As the number of patient interactions with non-hospital-based employees increases, so too does the importance of those interactions. To provide high-quality care, hospitals and health systems must ensure that data can be transmitted effectively from site to site. Such transmissions are also a prerequisite for ensuring that the patient experience is consistently good across sites. However, establishing seamless data transmissions can be incredibly challenging—and if not done well, significant collection issues can arise downstream. As a first step in addressing these challenges, providers will need to establish platform interoperability across their full portfolio of locations.

<sup>14</sup>Chui M et al. Where machines could replace humans—and where they can't (yet). *McKinsey Quarterly*. July 2016.

<sup>15</sup>Kunte A et al. Chronic disease excellence: “Service line 2.0” for health systems. McKinsey white paper. April 2018.

**EXHIBIT 6 Questions to consider when embarking on a journey toward revenue excellence**

<p><b>Establishing cross-functional ownership</b></p>	<p><b>Enhancing patient engagement</b></p>
<ul style="list-style-type: none"> <li>• Do we have the <b>right performance metrics and incentives</b> in place to ensure everyone is working toward a common goal?</li> <li>• What tools and talent do we have in place to <b>effectively coordinate with different functions outside of RCM</b> as well as other stakeholders (payers, employers, etc.)?</li> <li>• What barriers make it difficult to <b>more effectively join our operating teams</b> across the organization?</li> </ul>	<ul style="list-style-type: none"> <li>• Is our system’s <b>patient collection process optimized from beginning to end</b> (e.g., do we have flexible payment options for patients via a digital platform, use analytics to segment patients based on willingness and capacity to pay)?</li> <li>• Have we <b>created stickiness for patients</b> within the health system when they need care?</li> <li>• Do we have the <b>right team and structure</b> to shift the way in which we engage patients?</li> </ul>
<p><b>Digitizing and automating operations</b></p>	<p><b>Optimizing RCM across sites</b></p>
<ul style="list-style-type: none"> <li>• Have we <b>redesigned back-office operations within the past five years</b>? If not, are our <b>operations taking advantage of technology advancements</b>?</li> <li>• Do our managers <b>leverage data and analytics</b> in day-to-day work (e.g., performance management, prioritization of work, strategic decisions)?</li> <li>• How does our organization make <b>RCM-related capital investments</b> today?</li> </ul>	<ul style="list-style-type: none"> <li>• How can RCM teams <b>encourage and facilitate the development of a truly caring culture</b> to ensure that patients are receiving the <b>appropriate care in the right location</b>?</li> <li>• What level of interaction or overlap exists today between the <b>billing teams and physicians or hospitals</b>? For the patient access teams?</li> <li>• What organizational changes would we need to address to <b>ensure accountability for results across different functions</b>?</li> </ul>

RCM, revenue cycle management.

**Standardizing operations.** When employees are scattered across geographic sites, it can also be quite difficult to standardize and optimize core revenue cycle operations, particularly complex ones such as the financial clearance process. At present, many providers must cope not only with different sites of care but also with different claim types (facility and professional) and different IT systems. Even providers with a unified patient accounting platform typically engage multiple vendors for reporting, referral management, authorizations, and other RCM tasks. Revenue excellence requires that providers adopt a more unified approach to processes, systems, and data, which often means that they must rethink their

IT platform. Without this unified approach, standardizing and optimizing core operations is likely to be impossible. As an example, consider the impact that well-trained front-end RCM teams can have on referrals. These teams are well positioned to help retain patients in-network; however, the lack of interoperability and standard processes makes it difficult for them to do so.

**Ensuring consistent patient experience.** Ensuring that the patient experience is consistently good throughout the system is challenging when the patient-facing staff is decentralized and has minimal oversight. Most inpatient teams are centralized, and thus hospital and health

system executives can monitor and optimize the patient experience through strong central oversight. As care increasingly shifts to outpatient settings, however, those executives must ensure that all staff members deliver a good patient experience, regardless of the site or type of care. A good patient experience makes it easier to engage with patients—which, in turn, can improve collection rates.



The healthcare payment and collections landscape has changed significantly over the past several years, which has created new collections challenges for providers. Providers that can respond effectively to these changes will be well positioned for success in the future. Increased training and cross-site apprenticeship opportunities for revenue cycle leaders can help them accomplish this. Provider executives should remember, however, that the next generation of revenue cycle leaders—the ones who can make revenue excellence possible—may not always come from “locally grown”

managers in traditional inpatient departments. Instead, providers may want to look for talent, and new perspectives on revenue topics, in all parts of their organization, not just the RCM team.

Provider executives that want to achieve revenue excellence should start by taking a hard look at their current operations to better understand how prepared they are to more effectively manage their revenue streams. The questions included in Exhibit 6 can help executives better understand their current revenue cycle performance and what they will need to do to transform their performance to achieve revenue excellence. ○

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